Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DASHE ORTHOPEDIC SUPPLIES
SUITE 105
5445 LA SIERRA DRIVE
DALLAS TX 72531

Respondent Name
INSURANCE CO OF THE STATE OF PA

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-10-2718-01

MFDR Date Received
February 4, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The first payment of $14.26 was an incorrect payment for item E0218. The problem is that you have only paid for one day of this seven day rental. I have pointed this out to your employee Sharon on two separate occasions, 11/16/09 & 12/15/09. On the EOB that was sent to us by you, it shows the number one under the column labeled units. This number should be seven as that is the number of days the injured employee had the item per the pre-authorization we were given the correct paid amount we should receive is $99.82. subtract the $14.26 you have already paid and we are still owed $85.56. I have not received any form of an answer as to why you continually refuse to correct your mistake in regards to this issue."

Amount in Dispute: $85.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The insurance carrier has reviewed the Medical Fee Dispute Resolution Request/Response (DWC-60). In reviewing the report, it is the carrier's position that the medical bill paid correctly. E0218 is a rental item and per the DME guidelines – one (1) unit is equal to up to 31 days rental. The provider is billing seven (7) units for the seven (7) days. Had the units been left at seven (7), the provider would have received seven (7) months rental payment. The carrier reviewed the dates of service for this medical bill and other bills in patient history, and ensured that the number of units represents the appropriate monthly amount because some providers may bill the number of units as the number of days. The monthly amount for E0218 that is allowed is $82.95; when you divide that by 31 days time 7 days rented, it equals $18.73 minus the PPO discount for a payment of $14.26."

Response Submitted by: Chartis Dallas Workers' Compensation Service Center

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 26, 2009-October 2, 2009	E0218	$85.56	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 1 (45) – Charges exceed your contracted/legislated fee arrangement
   - 2 (W1) – Workers Compensation State Fee Schedule Adjustment
   - 3 (217) – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement

Issues

1. Was the workers' compensation insurance carrier entitled to pay the health care provider at a contracted rate?
2. Did the requestor bill for a monthly rental?
3. Did the requestor submit documentation to justify that the amount being sought is a fair and reasonable rate of reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced disputed services with reason code "1 (45) – Charges exceed your contracted/legislated fee arrangement." Review of the submitted information found insufficient documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on October 4, 2010 the Division requested the respondent to provide a copy of the referenced contract as well as documentation to support notification to the healthcare provider, as required by 28 Texas Administrative Code §133.4, that the insurance carrier had been given access to the contracted fee arrangement. Review of the submitted information finds that the documentation does not support notification to the healthcare provider in the time and manner required. The Division concludes that pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.203(b)(1) "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor seeks reimbursement for HCPCS code E0218 rendered on September 26, 2009 to October 2, 2009. The AMA CPT code book defines E0218 as "Water circulating cold pad with pump." The CMS reimburses HCPCS code E0218 on a monthly basis. The requestor seeks reimbursement for a daily rental (x 7 days).
3. Per 28 Texas Administrative Code §134.203 "(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: (1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or (3) if neither paragraph (1) nor (2) of this subsection apply, then as calculated according to subsection (f) of this section."

   Review of the Medicare DMEPOS fee schedule and the Texas Medicaid fee schedule did not contain a published fee schedule as a result, the disputed CPT code will be reviewed pursuant to 28 Texas Administrative Code §134.203 (f).

   Per 28 Texas Administrative Code §134.203 "(f) For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

4. Former 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor did not submit documentation to support that $85.56 is a fair and reasonable rate of reimbursement.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for HCPCS code E0218 in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the service in dispute. Additional payment cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 18, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.